

Zimbabwe

Final Country Report

May10, 2000

The goal of the Family Planning Service Expansion and Technical Support (SEATS) Project is to expand access to and use of high-quality, sustainable family planning and reproductive health services.

John Snow, Inc. (JSI), an international public health management consulting firm, heads a group of organizations implementing the SEATS Project. These include the American College of Nurse-Midwives (ACNM), AVSC International, Initiatives, Inc., the Program for Appropriate Technology in Health (PATH), World Education, and partner organizations in each country where SEATS is active.

This publication was made possible through support provided by the Office of Population and the Bureau for Africa, the Office of Sustainable Development, United States Agency for International Development (USAID) under the terms of Contract No. CCP-C-00-94-00004-10, and by JSI. The contents and opinions expressed herein are those of the authors and do not necessarily reflect the views of USAID or JSI.



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Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ARO	Africa Regional Office
CA	Collaborating Agency
CBD	Community based distribution
CPR	Contraceptive prevalence rate
CQI	Continuous quality improvement
CYP	Couple years of protection
DHS	Demographic and Health Survey
FHP	Family Health Project II
FP	Family planning
FPPMES	Family Planning Program Monitoring and Evaluation System
FPRG	Family Planning Referral Guide
GOZ	Government of Zimbabwe
HIV	Human Immunodeficiency Virus
ICO	Independent Clinics Organization
IEC	Information, education and communication
IPCC	Interpersonal communications and counseling
IUD	Intrauterine device
JHPIEGO	Johns Hopkins Program for International Education in Gynecology and Obstetrics
KWA	Kunzwana Women's Association
LAM	Lactational amenorrhea method
LTPM	Long-term and permanent methods
M&E	Monitoring and evaluation
MAPS	Midwifery Association Partnerships for Sustainability
MAQ	Maximizing Access and Quality Initiative
MOH	Ministry of Health
MWRA	Married women of reproductive age
NGO	Non-governmental organization
PROFIT	Promoting Financial Investment Transfers Project
PSI	Population Services International
PVO	Private voluntary organization
RH	Reproductive health
RHC	Reproductive health care
RHII	Reproductive Health Integration Initiative
SDP	Service delivery point
SEATS	Family Planning Service Expansion and Technical Support Project
STD	Sexually transmitted disease
STI	Sexually transmitted infection
TA	Technical assistance
TFR	Total fertility rate
TFU	Trainee follow-up
UBH	United Bulawayo Hospital
U.S.	United States
USAID	United States Agency for International Development
VSC	Voluntary surgical contraception
WRA	Women of reproductive age
ZINA	Zimbabwe Nurses Association
ZNFPCC	Zimbabwe National Family Planning Council

I. EXECUTIVE SUMMARY

The Family Planning Service Expansion and Technical Support (SEATS) Project began working in Zimbabwe during SEATS I (1989-1994). During this time, SEATS established its Africa Regional Office (ARO) in Harare, Zimbabwe and began implementing five subprojects, as well as its Special Initiatives and studies, throughout Zimbabwe. During this time, SEATS participated in the Sub-Saharan Africa Urban Family Planning Study. This study, funded by the Africa Bureau of the United States Agency for International Development (USAID), examined how family planning service delivery programs in Sub-Saharan Africa cities could become more efficient and effective, and served as the genesis for SEATS' Urban Initiative.

The SEATS II project continued the momentum gained in Zimbabwe under SEATS I, maintaining its collaboration with municipalities, the Ministry of Health (MOH), Zimbabwe National Family Planning Council (ZNFPD) and non-governmental organization (NGO) service providers and managers.

To support USAID and the Government of Zimbabwe in their goals of reducing the national fertility rate and increasing the sustainability of family planning programs, SEATS identified strategic objectives that supported and strengthened municipal level family planning training capacities; expanded the availability and use of long-term family planning methods; and addressed constraints and opportunities for service delivery in underserved areas and for special populations. To do so, SEATS based its strategy in Zimbabwe on the following key activities: the integration of services to achieve a broader reproductive health approach; a focus on youth and groups with special needs; an over-arching quality improvement component; and development of underutilized service provider capacity.

During the past five years, SEATS II has worked with the public sector, private sector, cooperating agencies and international partners to implement six subprojects:

- ◆ Bulawayo Family Planning Service Delivery: Support for Quality Improvement and Training;
- ◆ Expanded Access to voluntary surgical contraception (VSC) in Bulawayo: An Urban Initiative Subproject
- ◆ Chitungwiza Family Planning Services: Comprehensive Training for Quality Improvement;
- ◆ Gweru Family Planning Service Delivery: Support for Quality Improvement and Training;
- ◆ Gweru Youth Reproductive Health Project;
- ◆ Expanding family planning and sexually transmitted infection (FP/STI) Services by Private Nurses and Midwives in Zimbabwe.

As a result of these subprojects, as well as additional activities supported by SEATS (e.g., regional activities), clinical and provider service delivery points have expanded and improved. To improve the quality of services at these points, each subproject participated in the Maximizing Access and Quality (MAQ) study and developed, along with their respective facilities, quality action plans to introduce and incorporate quality of care awareness and techniques. SEATS has also worked with the subprojects to integrate several of its Special Initiatives into their services.

Overall, SEATS successfully increased access and improved quality in most sites in the Zimbabwe subprojects:

- ◆ A total of 2,082 people were trained in a wide range of FP topics;
- ◆ The average Couple years of protection (CYP) increase was 31 percent in the subprojects;
- ◆ A total of 221,939 CYP were generated;

- ◆ In approximately a three-year period 110,143 new users were served;
- ◆ Method mix was also broadened, with long term methods and condoms increasing in popularity and as a consequence, reducing Zimbabwe's heavy dependence on pills.

Because of the enormity and complexity of the SEATS activities in Zimbabwe, this document can only provide an overview of the Zimbabwe program elements, results and lessons learned. For further details on the specific subprojects, each of the final subproject reports is appended to this Final Country Report (Volume II).

II. PROJECT BACKGROUND

A. Country Background

Zimbabwe is a landlocked republic in southern Africa that gained independence in 1980. It has a population of approximately 10.5 million, the majority comprised of two major ethnic groups, the Mashona and the Ndebele (Matabele). More than half the population is Christian. Education and employment in Zimbabwe are relatively high compared to many neighboring countries, with a 90 percent literacy rate for men, 80 percent for women; and a workforce including 67 percent of the men and 33 percent of the women.

Family planning services have been available in Zimbabwe since 1953, with the first family planning association established in 1965. In 1976, the Ministry of Health approved 'field educators' - the basis for today's community-based distribution (CBD) system. In 1980, the family planning association was changed to the Child Spacing and Family Planning Council which in 1985, became ZNFPC, a state agency which is now one of the major FP providers in Zimbabwe. ZNFPC has 34 clinics and a CBD system of over 700 trained agents covering about 30 percent of the rural population. Also in 1985, the ruling party congress resolved to promote family planning not just for child spacing, but to limit family size.

1. Demographic and Health Indicators

The average annual population growth rate during the last inter-census period was 3.1, indicating a population doubling time of 22 years. Women of reproductive age (WRA), comprising 23.5 percent of the total population, are increasing at a rate higher than the average growth rate. The 1992 census found that 45 percent of the population was less than 15 years of age.

Infant mortality declined between 1978 and 1990 from 83 to 66 infant deaths per 1,000 live births. Child mortality (age 1-4 years) decreased from 37 to 26 during the same period. Maternal mortality remained relatively high at 395 per 100,000 live births.

Cases of Human Immunodeficiency Virus (HIV), tuberculosis, hepatitis, malaria and sexually transmitted diseases (STDs) have increased dramatically in the country in recent years. Life expectancy in Zimbabwe is now 49 years, while five years ago it was 61 years. According to the United States (U.S.) Census Bureau, this significant drop is attributed to the spread of AIDS.

Zimbabwe has 174 hospitals and 1320 doctors serving the entire country, and only about 2.58 percent of gross national product is spent on health care. Lack of resources at hospitals and clinics precludes widespread testing for HIV; so many people's status remains unknown.

Total fertility fell from 6.5 in the early 1980's to 5.5 in 1988 and 4.39 in 1994. The crude birth rate is 34.5. Women in urban areas experience lower fertility levels than women in rural areas, where total fertility rates (TFR) are 4.51 and 6.66 respectively. More than 40 percent of women experience their first birth before the age of 20.

City populations in Zimbabwe are growing twice as fast as the overall population due to urban migration. In 1992, 30.6 percent of the population lived in urban areas; that figure was projected to reach 36 percent by 2002. In the following decade, Harare's urban population was expected to increase by 39 percent and Bulawayo's by 40 percent. This rapid urban growth poses a serious challenge to already taxed health and family planning services.

2. Family Planning in Zimbabwe

Following independence in 1980, the Government of Zimbabwe (GOZ) became acutely aware of the importance of family planning in the promotion of maternal and child health. Zimbabwe has a national family planning policy that was published in October 1998 and a family planning strategy for 1997 to 2002. The GOZ strongly promotes family planning. The GOZ National Population Report, presented in Cairo in 1994, reflected government priorities to reduce the population growth rate from 3.1 percent to a lower sustainable rate by the year 2000 to ensure a population size in better balance with economic development.

Zimbabwe pursued a first five-year (1991-1996) strategy for the National Family Planning Program that provided a framework for major donor inputs into the national program. The goals were to:

- ◆ Reduce the TFR to 4.5 by 1996 (achieved).
- ◆ Increase the financial sustainability of the family planning program while providing high quality services and ensuring access to low income clients.

By the end of 1995, Zimbabwe had developed one of the most successful FP programs in Africa. According to the Zimbabwe Demographic and Health Survey (DHS) of 1994, the TFR had decreased from 6.5 in 1984 to 5.5 in 1988, and 4.3 in 1994 – an impressive achievement. The contraceptive prevalence rate (CPR) for all WRA was 35 percent, while among currently married women in 1994 it was 48 percent, and the modern method CPR was 42 percent. Fifteen percent of married women reported a desire to postpone their next pregnancy, or have no more children, but were not using a method, indicating a significant unmet need for FP.

Knowledge of family planning is nearly universal in Zimbabwe, but there is a large gap between knowledge, availability of accurate information on all methods and use of modern methods. Most acceptors (78 percent) use oral contraceptives, but even in 1994 there was a small but growing percentage (7.6 percent) using Depo Provera. Thirty six percent of married women of reproductive age (MWRA) reported desiring no more children, indicating a potentially large unmet need for sterilization, which accounts for only five percent of current users. As a result of the method mix reported by DHS, SEATS subprojects offered more Depo Provera, sterilization and condoms. The increase in condom use was especially noteworthy over the course of the project. The trends reflect SEATS' aim to simultaneously address potentially conflicting needs: to increase long-term and permanent methods (LTPM) use and to promote condom use for HIV prevention.

The urban centers of Harare/Chitungwiza and Bulawayo have the highest CPR of 57.7 and 44.8 respectively. However, recent FP service delivery capacity analyses (Bulawayo Urban Study – SEATS I) indicate a dramatic increase in urban service delivery load in the years to come (i.e., by 2005, an estimated additional 150,000 client contacts per year in Bulawayo).

Family planning services are provided through a network of both government and private hospitals, rural health centers, municipal clinics, ZNFPC clinics, mobile units and over 700 CBDs. While CBDs cover much of rural Zimbabwe, there remain vast rural areas with poor access to needed services.

The ZNFPC strategy cites, among several vital components: the expanded use of LTPM; an increase in the number and type of service providers; and a focus on high-quality integrated service delivery. Many programs are proposed or currently underway to address specialized areas of need, such as private sector expansion, reducing medical barriers, policy reform and cost recovery.

3. Donor Contributions and Strategies

In addition to GOZ funding, the National Family Planning Program receives assistance from a consortium of donors headed by the World Bank, supporting the nationwide Family Health Project II (FHP II) which focuses on training and institutional support to the MOH. The Swedish International Development Agency, Danish International Development Agency, German Technical Cooperation and Norwegian Agency for Development provide bilateral support through FHP II. The United Nations Population Fund supports the development of the national population policy, multi-sectoral information, education and communication (IEC) activities and operations research. The British Department for International Development is supporting a STI project, including national condom procurement over a five-year period. USAID funds several cooperating agencies (CAs) working in reproductive health, social marketing and IEC.

III. GOALS AND OBJECTIVES

The Zimbabwe National Family Planning Program has been highly successful in expanding and providing family planning services nationwide through CBD and fixed service delivery points (SDPs). While national demographic targets were on track according to the 1994 DHS, significant programmatic changes were required to assure ongoing expansion and sustainability. Continued rapid population growth and the high rate of rural to urban migration were exerting ever-increasing pressure on health and FP services, particularly in urban areas. ZNFPC and the GOZ are committed to addressing the country's growing needs; and USAID's strategic objectives were designed to support the evolving program.

A. *USAID/Zimbabwe Strategic Framework*

The USAID/GOZ bilateral program (1994-1998) aimed to reduce fertility through three strategies:

- 1) increased participation in private sector FP service delivery;
- 2) increased CPR through provision of LTPM; and
- 3) increased efficiency and cost effectiveness of the public-sector program. Two major outputs focused on service delivery and were of particular relevance to SEATS: greater access to a more diversified method mix and improved contraceptive use.

USAID planned an extensive program of specialized technical assistance (TA) to address the requirements of the bilateral program. CAs involved in providing this TA under the bilateral included: Johns Hopkins University/Population Communications Services, AVSC International, Johns Hopkins Program for International Education in Gynecology and Obstetrics (JHPIEGO) and MACRO International. The Promoting Financial Investment Transfers (PROFIT) Project was contracted to carry out a private-sector project and Population Services International (PSI) implemented a social marketing project.

In response to compelling findings of the regional urban family planning study conducted under SEATS I, USAID Zimbabwe expressed interest in developing an urban initiative under the bilateral program. In addition, ZNFPC requested that SEATS II undertake a service delivery project in an underserved rural area.

B. *SEATS Goal and Objectives*

SEATS' goal is to expand and improve the development of, access to and use of quality family planning and reproductive health services and information. In response to ZNFPC and USAID's interest in urban FP programming and service enhancement in underserved areas, SEATS developed the following objectives for its work in Zimbabwe:

1. Urban Family Planning

- ◆ Promote sustainable urban family planning service delivery by strengthening the training capacity within the Municipal Health Service of three to four cities;
- ◆ Expand the proportion of CPR attributable to long term and permanent methods in urban municipalities supported under SEATS;

- ◆ Institute a supervision-linked process of continuous quality improvement (CQI), incorporating CQI training and follow up.

2. Underserved Rural Districts

- ◆ Assess the constraints and opportunities for family planning service delivery in selected underserved districts, and design and implement appropriate service delivery strategies and interventions;
- ◆ Assist in expanding contraceptive prevalence in selected low-prevalence districts.

IV. SEATS COUNTRY STRATEGY AND PROGRAM

A. Country Strategy

To support USAID and the Government of Zimbabwe in their goals of reducing the national fertility rate and increasing the sustainability of family planning programs, the SEATS Zimbabwe strategy was built upon:

- ◆ Development of sustainable institutional capacity;
- ◆ Integration of FP services to encompass a broader reproductive health approach;
- ◆ An approach to FP which is inclusive of adolescents and groups with special needs;
- ◆ Collaboration between municipal, Ministry of Health (MOH), ZNFPC and NGO service providers;
- ◆ A program-wide quality improvement component;
- ◆ Development of underutilized service provider capacity; and
- ◆ A performance based programming approach.

Subprojects, Special Initiatives, special studies and other activities were designed to contribute to the overall strategies of the Zimbabwe National Family Planning Program and to the USAID bilateral agreement with GOZ. Additionally, SEATS sought to complement and enhance existing activities and contributions of CAs and donors in its implementation.

B. Country Program

1. Special Initiatives

An important feature of SEATS II was the development of several Special Initiatives. These provided an internal mechanism to support small pilot studies and projects to expand or improve reproductive health (RH) services or information using creative and innovative approaches which might serve as precursors to large scale programs and activities. SEATS' Special Initiatives include:

- ◆ Urban II Initiative: Maximizing Urban Resources;
- ◆ Reproductive Health Integration Initiative (RHII) into NGO/Private Voluntary Organization (PVO) Programs;
- ◆ Midwifery Association Partnerships for Sustainability (MAPS);
- ◆ Youth Initiative; and
- ◆ Women's Literacy Initiative.

Early assessment and discussions with ZNFPC and USAID/Zimbabwe indicated that several of the SEATS II Special Initiatives, such as the Urban Initiative and the MAPS Initiative might be appropriately integrated in the Zimbabwe country program.

Urban Initiative for Urban Family Planning

SEATS proposed to undertake subproject work with three urban centers: Chitungwiza, Bulawayo, and Gweru. These cities were identified as a result of SEATS I involvement in the Sub-Saharan Africa Urban Family Planning Study which examined how family planning service delivery programs in sub-Saharan African cities could become more efficient and effective. Discussions with municipal authorities, MOH and ZNFPC were formalized, and selection of target cities was based on: interest in participation; expressed need for resources and FP service enhancement; and statistical analysis of existing service delivery patterns using SEATS' Family Planning Program Monitoring and Evaluation System (FPPMES).

Based on national strategies, urban programming experience and Urban Study findings, strategic objectives for the cities subprojects would address:

- ◆ Improved method mix, increased access to LTPM;
- ◆ Development of training capabilities;
- ◆ Improved quality of services through CQI initiatives;
- ◆ Improved supervision of services;
- ◆ Enhanced integration of reproductive health services;
- ◆ Increased access for special target groups.

MAPS Initiative: Addressing Underserved Rural Districts

The 1994 DHS revealed a national CPR of 44 percent among MWRA. However, some rural areas figured far below the national average. Several factors may have contributed to low CPR, including: lower population density affecting access to services; geographically large provinces; settlement patterns that do not favor village or town development; poor transport infrastructure; and cultural patterns.

SEATS proposed to enhance FP service delivery in low prevalence rural provinces by working with midwives. Assessments were planned to identify cultural, programmatic, resource and logistical constraints to FP acceptance and delivery. Based on findings, IEC and other program activities were designed. MAPS experience and approaches were applied in developing creative and appropriate strategies including:

- ◆ Use of alternative community-based cadres for resupply methods in areas not covered by CBDs; and
- ◆ Routine scheduling of mobile family planning days in homestead areas.

2. Regional Activities

With SEATS' ARO established in Harare, Zimbabwe, it was the logical venue for several regional activities including conferences, workshops, and various training events. This permitted many Zimbabwe subproject staff to participate in the regional activities, as travel and support costs were minimal. Additionally, SEATS regional technical staff, including experts in management information systems, program planning and evaluation, IEC and more, were based in the Harare office, allowing ready access for Zimbabwe subprojects to a wide range of technical assistance. Technical and management staff from SEATS' headquarters in Washington traveled frequently to Harare to lead or help conduct regional activities and to provide further technical assistance to Zimbabwe subprojects and activities.

Based on the objectives and strategies outlined above, SEATS, in collaboration with partners in Zimbabwe, designed and implemented six subprojects, Special Initiatives, Special Studies

and a variety of regional training and dissemination events. SEATS actively collaborated with many other agencies and institutions including The Population Council, Centre for African Family Studies, JHPIEGO and AVSC. The implementation and results of these activities are described in the following section.

V. IMPLEMENTATION

SEATS' subprojects were designed during the latter half of 1995, with activities phasing in during the fourth quarter of 1995 and early 1996. Initial priority was placed on the procurement of equipment and on training, enabling subprojects to rapidly attain full implementation.

Special Initiatives (MAPS, Urban, Youth) and Technical Initiatives (Quality, Sustainability, Monitoring and Evaluation) were integrated to the maximum extent possible into subproject activities, rather than being developed as stand-alone activities. This approach helped assure that the subprojects, both individually and collectively, were technically sound and addressed the GOZ and USAID/Zimbabwe program strategies and needs. The Zimbabwe subprojects and SEATS regional activities in which Zimbabwe participated are described below.

A. *Subprojects*

1. **Bulawayo Family Planning Service Delivery: Support for Quality Improvement and Training**

After Harare, Bulawayo is the second largest city in Zimbabwe. The population according to the 1992 census was 621,743, of which 173,841 (28 percent) were WRA.

The 1994 DHS indicated that most (64 percent) of the FP services delivered in the city were by the public sector, which was marred by problems with staff shortages, high staff turnover, low FP training capacity, and lack of equipment necessary to deliver high-quality services. The only FP training facility, the ZNFPC Training Center, was at a large hospital that offered training for medical staff from four provinces in addition to Bulawayo. Only four Bulawayo City staff (limited to registered nurses) per year benefited from the ZNFPC training courses.

The SEATS subproject was designed to respond to the need for FP training by establishing a municipal training unit, training trainers to staff the unit, and training nurses to provide quality FP services. Additionally, the project also served as a mechanism to increase the capacity of the city to provide FP services to youth through special skills training in youth counseling.

The goal of the subproject was to “**improve the health of families in Bulawayo by strengthening the delivery of FP services in the city**” through the development of training capabilities, improved service quality, improved supervision, increased access to services by youth, improved method mix and increased access to LTPM.

A summary of the objectives and accomplishments of the subproject follow:

Objective 1: To expand use of FP services in Bulawayo by improving service delivery sites city-wide through training, quality improvement and expanded access to broad method mix

- ◆ Utilization of contraceptives continued to be dominated by oral contraceptives and Depo Provera. However, a positive shift in CYP is evident in the increased contribution of condoms from 18.5 percent in the first three quarters to 25.5 percent in the last three quarters of the subproject.
- ◆ The original aim of generating 40,000 CYP during the subproject was exceeded by 179 percent (71,669 CYP).
- ◆ Three providers were trained in interpersonal communication and counseling skills and they now support other staff who did not attend the training.

- ◆ In coordination with the Bulawayo VSC subproject (described below), a doctor/nurse team was trained in surgical contraception, and a VSC theater was established at Nkulumane clinic run by the City Health Department. The team performed 80 tuballigations during the subproject period.
- ◆ Coordination meetings were held between the Bulawayo subprojects, focusing on coordinating training, VSC counseling and the referral network.
- ◆ Two trainers attended lactational amenorrhea method (LAM) implementation training offered by ZNFPC and have subsequently trained FP providers and promoted LAM at the training sites. (A national LAM strategy has not yet been adopted by the MOH and ZNFPC).

Objective 2: To establish a family planning training unit within the Bulawayo City Health Department

- ◆ A training center was established at Tshabalala Clinic.
- ◆ Training equipment and materials were procured.
- ◆ Two additional training sites (Nkulumane and Nketa Clinics) were furnished and used for practical training.
- ◆ Training fees were introduced for non-City Health Department staff. By the end of the project, 23 providers paid for training.
- ◆ Three service providers were trained as FP trainers.

Objective 3: To improve local capacity to provide family planning services by training 120 nurses from Bulawayo in basic clinical family planning

- ◆ Using the national curriculum produced by ZNFPC, nine basic FP courses were conducted, with 93 nurses attending.
- ◆ At least one trained provider was posted to each of the 17 city council clinics.
- ◆ Two refresher courses were conducted for 40 nurses.
- ◆ The City Health Department has committed to continuing refresher training.

Objective 4: To establish a training follow-up system within Bulawayo

- ◆ Trainee follow-up tools for use during supportive supervision visits were adapted from ZNFPC, SEATS and AVSC.
- ◆ Fifteen trained providers were followed up using follow-up tools and most were found to be applying appropriate skills in provision of FP services.

- ◆ The training center developed a trainee follow-up (TFU) schedule visiting a sample of participants from each course and concentrating on those trainees who displayed the weakest skills during training.
- ◆ FP/Maternal and child health supervisors in all of the city council clinics were trained in the use of the TFU tools.

Objective 5: To increase access to family planning services for youth in Bulawayo by training 17 City Health Department nurses in youth counseling and service delivery

- ◆ Two people from the City Health Department staff were trained as trainers for youth-friendly services.
- ◆ SEATS sponsored one nurse from each of 10 municipal clinics to receive youth counseling skills and service delivery training offered by ZNFPC and the Rockefeller Foundation.
- ◆ Nurses trained in youth-friendly services provided information to youth and community members through churches, youth groups and schools.
- ◆ Staff trained by SEATS in youth-friendly services supported youth centers established under the Rockefeller Foundation program. Peer counselors trained by the ZNFPC/Rockefeller program collaborated with staff at the city health clinics.
- ◆ Youth-friendly environments were adopted in 17 clinics.

Consistent with SEATS' approach to include CQI in all of its activities, representatives from the subproject participated in regional CQI training conducted by SEATS in Harare in 1997, and in follow-up training in 1998. Based on the training, the subproject developed and implemented a quality action plan.

As a result of this subproject:

- ◆ FP training has been fully adopted by the Bulawayo City Council and it is committed to providing continued financial and management support.
- ◆ The City Health Department has acquired experienced trainers in basic FP and LAM.
- ◆ Nurses and qualified individuals in Bulawayo now have an opportunity to sponsor themselves for quality basic FP training at an affordable cost.
- ◆ All 17 city clinics now have trained FP staff to increase access to quality FP/RH services.

Notwithstanding these important achievements, several challenges and constraints were encountered in implementing the subproject. For example, staff shortages resulted in a decreased number of trainees who benefited from the trainee follow-up system, the abandonment of the planned interpersonal communications and counseling courses, and a limit in the number of trainees.

The Final Subproject Report appended to this document provides details on the activities and achievements of the subproject.

2. Expanded Access to VSC in Bulawayo: An Urban Initiative Subproject

Bulawayo was one of three cities studied in an in-depth situation analysis under the SEATS I Urban Family Planning in Sub-Saharan Africa Study. It was also one of 10 surveillance sites for family planning in the Zimbabwe FPPMES. Hence, in 1996, at the start of the subproject, there was already significant information available about it.

The Urban Study found that the contraceptive method mix in Bulawayo was primarily comprised of resupply methods, causing heavy current and future client loads on clinics with few resources. Demand for LTPM was larger than the supply available. The 1994 DHS indicated that almost three fourths of currently married women either wanted no more children or wanted to wait for two or more years before having the next child. At the same time, most modern method use was from oral contraceptives. There was a clear need to improve the infrastructure to expand the method mix and meet the demand for LTPM in Bulawayo, to expand the skills of service providers, and to remove cumbersome administrative routines that posed barriers to LTPM.

In this subproject, SEATS proposed to work with two large public hospitals in Bulawayo (Mpilo Hospital and United Bulawayo Hospital) to expand VSC services while providing a linkage to the ongoing FP training subproject with the City Health Department (described above). The overall goal of the subproject was to **“increase the availability of and access to VSC services in Bulawayo, thereby expanding the number of acceptors.”**

The following is a summary of the objectives and accomplishments of the subproject:

Objective 1: To establish a VSC theater at United Bulawayo Hospital (UBH)

- ◆ A previously condemned building at UBH was renovated and provided VSC (with an emphasis on mini-laparotomy and vasectomy); FP services including intrauterine device (IUD) and Norplant® insertion and removal; antenatal care; IEC; and other RH services (PAP smear, physical assessment, referral).
- ◆ At Mpilo Hospital, an old theater was renovated into a VSC theater. This activity was not originally planned but Mpilo Hospital management approved and funded the theater, equipment and IEC materials, because of the increased demand for VSC services. It has been used for on the job training of doctors and nurses who rotate to Mpilo before being transferred to rural districts.

Objective 2: To increase the number of VSC trained staff in Bulawayo

- ◆ Four doctor/nurse teams (two from Mpilo, one from UBH and one from the City Health Department) were trained in VSC mini-laparotomy under local anesthesia and certified as trainers of trainers.
- ◆ SEATS supplied minilaparotomy kits to the Mpilo theater, while other equipment was furnished by the hospital.
- ◆ By the close of the subproject, 22 doctors, nine nurses and two clinical officers had received on the job training.
- ◆ By the end of the subproject, 30 providers were trained in interpersonal communications and counseling (IPCC).

Objective 3: To make the Bulawayo FP program more VSC friendly

- ◆ With assistance from AVSC, an assessment was undertaken to look at programmatic approaches and administrative and service delivery routines that might be counter productive to VSC.
- ◆ Informed consent requirements for VSC procedures were simplified.
- ◆ Hospital staff was oriented to VSC, including 17 providers oriented to AVSC's Site Training/In-reach Approach; 11 facilitators oriented to conduct whole site orientation; and 289 hospital staff oriented in the availability of VSC services.
- ◆ A Subproject Coordinating Committee was established and met quarterly to guide and monitor project activities.
- ◆ Administrative barriers were reduced (i.e. a duty roster was established for doctors on-call for VSC).

Objective 4: To increase the proportion of CYP attributable to VSC from 17 percent to 25 percent citywide over the life of the project

- ◆ During the subproject, a total of 1,978 VSC procedures were performed by United Bulawayo Hospital (UBH) and Mpilo, capturing both interval and postpartum clients. (Since ZNFPC and private practices in Bulawayo were not part of the SEATS subproject, their services were not monitored or included in the SEATS calculations).
- ◆ At UBH and Mpilo, there were 524, 867 and 485 VSC procedures performed in 1996, 1997 and 1998 respectively. This did not meet the subproject target of 25 percent of CYP. Oral contraceptives and Depo Provera, however, remained the dominant methods accounting for 55 to 71 percent CYP each quarter.

Consistent with SEATS' approach to include CQI in all of its activities, representatives from this subproject participated in a regional CQI training conducted by SEATS in Harare in 1997. Based on the training, the Bulawayo VSC subproject developed a quality action plan; identified elements upon which to focus (technical competence, counseling and client information, appropriateness and acceptability of services, and choice of methods); and selected sentinel indicators (proportion of service providers trained in the provision of long-term methods and service providers competent in the provision of FP) to monitor their progress.

The Bulawayo VSC subproject increased the number of service delivery points providing VSC services. There are now four active teams at the two subproject sites. The integration of the VSC program with the basic FP training at the City Health Department assures improved counseling and method choice. The two hospitals provide a pool of experienced trainers for both basic FP and VSC, a resource the GOZ can use to introduce the VSC program in other parts of the country.

Of course, the subproject operated under constraints. The prolonged plan approval process for building renovations delayed VSC training by as much as one year. The rotation system used to deploy junior doctors led to the loss of trained VSC providers from UBH to Mpilo Hospital. Doctors' strikes and the shift of many mid-level doctors from public to private service provision meant fewer trained providers would stay with their institutions. Staff shortages resulted in few providers being released from their routine responsibilities to participate in IPCC training. Finally, the monitoring functions of the Subproject Coordinating Committee were not clearly defined or routinely implemented. These are all issues that must be addressed in the near future to ensure the sustainability of the program.

The Final Subproject Report appended to this document provides further details on the activities and accomplishments of this subproject.

3. Chitungwiza Family Planning Services: Comprehensive Training for Quality Improvement

Chitungwiza, with an estimated population of 350,000, is the third largest city in Zimbabwe. It was created in the 1970's as a dormitory town to house the African population working in the capital city. Four municipal clinics and private providers (including doctors and pharmacies) provide family planning and reproductive health services. Condoms are also dispensed in shops, supermarkets and kiosks. Chitungwiza health facilities serve not only local residents, but also adjacent rural communities and farming areas. This increases the catchment population of WRA to approximately 100,000. Other demographic indicators include an estimated annual growth rate of 3.14 percent, a TFR of 4.8 and CPR of 57 percent. The FP service delivery pattern is similar to other urban areas of Zimbabwe, with a pill-dominated profile and growing use of injectables and condoms. Relatively few people opt for VSC, as none of the municipal clinics can provide the service. In 1995, IUD acceptance in Chitungwiza was low (12 acceptors per quarter), and Norplant® was not provided.

The Chitungwiza subproject was designed to address identified training needs, expand the method mix available to the population, improve the provision of counseling, and upgrade physical facilities for FP service provision. The overriding goal was to **improve access to and quality of FP/RH services.**

A summary of the objectives and accomplishments of the subproject follow:

Objective 1: To raise and sustain the proportion of FP trained nurses from 50 percent to 85 percent in Chitungwiza public-sector facilities

- ◆ A total of 152 nurses were trained in FP. This, in addition to the 34 previously trained nurses, totals 186 FP trained nurses. Due largely to the high attrition rate of nurses (approximately 20 per year), this figure represents 48 percent of all the nurses in Chitungwiza.
- ◆ Forty-five providers were trained in IPCC.
- ◆ Training of trainers and provision of equipment create the capacity for Chitungwiza to conduct courses for the entire municipality and surrounding areas.
- ◆ Trainee follow-up was instituted and utilized, allowing trainers to monitor the quality of services and evaluate trainees' performance on-the-job and introduce remedial action in refresher training.

Objective 2: To expand and consolidate Chitungwiza's training capability to include on-the-job IUD and VSC training

- ◆ Two nurses were trained in a training of trainers for IUD insertion.
- ◆ Eight nurses were trained on-the-job in IUD insertion, and were certified competent by ZNFPC.
- ◆ Four refresher courses including promotion of LTPM were conducted, training 56 providers.

Objective 3: To more than double VSC and IUD acceptance project-wide, and to introduce LAM and Hormonal Implants (Norplant®) on a trial basis

- ◆ At the end of the subproject, there were 70 new IUD users per quarter. This is a 113 percent increase from before the subproject began.
- ◆ In 1996, VSC rates averaged 19 per quarter. In 1997, it reached 53 per quarter, decreasing again to 14 per quarter in the final year (1998) of the subproject.
- ◆ Method mix continued to be dominated by pills and condoms, and did not change dramatically over the life of the subproject.

Objective 4: To upgrade facilities and equipment in six sites to enable improved quality of care

- ◆ The four municipal clinics turned their large reception rooms into private counseling cubicles. With these facilities, the nurses counseled an average of 80 clients per day at each clinic.
- ◆ At the Seke South Clinic, the Chitungwiza training clinic was renovated to provide counseling and to improve the waiting area. IEC, audio-visual, and office equipment and materials were provided.

Objective 5: To achieve 40,000CYP

- ◆ Total CYP for the first quarter of the project was 3,433 and it rose to 5,840 by the last quarter. The target of 40,000 was exceeded, with a total life of project CYP of 66,680.

This subproject also developed a quality action plan that guided the implementation of its activities. Client satisfaction was paramount in each quality objective. The program's overall focus, highlighted through quality activities, was on the individual client.

At the conclusion of the program, Chitungwiza conducted a mini-survey with a sample of 108 female clients to assess the extent to which clients' needs had been met. The majority of clients interviewed reported a high level of satisfaction with the services they received. Most (99 percent) were using modern methods and the majority (73 percent) used short-term methods. They received adequate counseling prior to selecting a method. Eighty-seven percent reported that they had been informed of possible side effects of particular methods. The majority was examined on their initial visit to the clinic and 79 percent of those had been examined in privacy. Most confirmed that the examination rooms were clean.

Twenty-four nurses were also interviewed for their perceptions of services. While they expressed interest and satisfaction in their work, many identified the need for additional training to upgrade their skills. Many required training in counseling, particularly with regard to patients afflicted with HIV/Acquired Immune Deficiency Syndrome (AIDS).

Developing a quality action plan caused staff to focus on this important area, to monitor progress and to determine their level of success over the course of the subproject. Monitoring provided management staff with data to use in decision-making, both now and in the future.

Chitungwiza, like other subprojects, was constrained by the chronic shortage of staff at public facilities, resulting in low numbers of trainees. Managers were understandably reluctant to release nurses and other staff for training, when staff left at post would have been unreasonably overworked, thus compromising the quality of care provided. Consequently, fewer staff were trained than anticipated and hoped for. The decision to train for IUD insertions on-the-job meant that only a limited number of staff could be taught. Difficulties with transportation hampered on-site supervision which is an integral part of trainee follow-up.

Clinic renovations posed further constraints, as the approval processes were weighty, and delays resulted in some renovations undertaken only at the end of the subproject. Political

and policy issues precluded use of the only available operating theater for VSC. Financial transactions between ZNFPC (the SEATS recipient) and the Municipality of Chitungwiza (the implementing agency) were cumbersome and not always timely. These constraints all contributed to less than complete achievement of subproject objectives.

The Finals Subproject Report appended to this document provides further details on the activities and accomplishments of this subproject.

4. Gweru Family Planning Service Delivery: Support for Quality Improvement and Training

Gweru is the fourth largest urban center in Zimbabwe. It is the capital city and main market center for the large Midland Province. The greater Gweru area has a population of about 213,235 people, with the city itself at 128,037 (1992 census). The MOH Provincial Hospital, one ZNFPC clinic, seven Gweru city health clinics, one PSI/Zimbabwe clinic, 12 industrial clinics, five military facilities and 11 private practitioners provide family planning services. The 1992 census reported a TFR of 4.34 for Gweru, and approximately 50,000 WRA.

The goal of the Gweru subproject was **to improve the health of families in Gweru by strengthening the delivery of family planning services in the city.** Gweru City Health Department attached the greatest importance to FP training for its staff. The “supermarket” approach adopted by many health services in Zimbabwe, along with the policy of staff rotation, demanded that all nursing staff be skilled in the provision of FP services. It was estimated that of over 426 nurses in various health facilities in Gweru City, 76 percent (325) had not been trained in FP service skills. This presented an urgent need to initiate a training program that would ensure a skilled work force to respond to the increasing demand for services. The Gweru subproject was designed to increase access to and quality of services, including expanded method mix, through the development of training capabilities and improved supervision. SEATS, ZNFPC and the Gweru City Health Department worked in partnership to implement the subproject.

A summary of the objectives and accomplishments of the subproject follows:

Objective 1: To assist Gweru City Health Department in establishing a Family Planning Training Unit to improve quality of FP services and promote improved method mix

- ◆ A committee composed of representatives from the City Health Department, the MOH (through Gweru Provincial Hospital), ZNFPC and PSI/Zimbabwe was established to guide and monitor project implementation.
- ◆ A bookkeeper was provided by SEATS to facilitate procurement activities and to oversee financial procedures.
- ◆ The male wing of Mkoba Clinic was refurbished as a training site with the capacity to train 20 participants at a time.
- ◆ Furniture, audiovisual equipment, photocopier, computer and printer were procured.

Objective 2: To improve local capacity to provide family planning services by training 90 nurses in basic clinical family planning and 30 nurses in interpersonal communication

- ◆ Two Gweru nurses were trained as trainers at the ZNFPC training site in Bulawayo, and an additional ZNFPC trainer was seconded to Gweru to assist in the initial trainings by the newly trained trainers.

- ◆ Eighty-three nurses (92% of target) from a variety of institutions citywide were trained in basic family planning. The course did not include IUD insertion as originally planned.
- ◆ ZNFPC originally provided transport for trainees. Trainees later shared the cost in order to foster sustainability of training.
- ◆ Six sessions of refresher training were held. Forty-three nurses/service providers attended the sessions.
- ◆ Forty-five providers (150% of target) attended IPCC training in five sessions.

Objective 3: To establish a training follow-up system within Gweru

- ◆ Seven trainees were followed up using TFU tools to determine their support needs, identify areas for further training and reinforce good service practices.
- ◆ Physical examination and infection control were identified as areas for refresher or additional training and supervision.
- ◆ Facility audits were conducted during follow-up.
- ◆ Gweru City Health Department has adopted the TFU, and adapted it to make it suitable for other areas of service provision.
- ◆ A system was established to ensure that all clinic nurses would be able to use TFU tools and report findings to the central City Health Office.

This subproject, like others, emphasized quality improvement and training in CQI. In a quality plan added during a regional CQI training by SEATS in 1997, Gweru elected to focus on technical competence of providers and the appropriateness and acceptability of services. Its objectives included: training City Health Department and mid-level managers in CQI concepts and skills, establishing a quality team at the City Health Department, and creating guidelines for monitoring services in clinics. These additional objectives were met through orientation and training sessions, supportive supervisions using checklists, and the design and implementation of client exit interviews to monitor client satisfaction with services. The quality team was formed and met monthly to identify and propose solutions to service problems.

The subproject achieved most of its objectives. The training center within the City Health Department and the FP training program have been fully adopted by the Gweru City Council. Training skills are available in the city; providers continue to receive FP training; and an increased number of trained providers are operating in Gweru. Non-city health staff have access to FP training through the City Health Department training center. CQI has been institutionalized within the City Health Department, and a trainee follow-up system is in place.

Several constraints, however, precluded complete achievement of subproject objectives. Again, due to staff shortages, fewer persons were trained than originally planned. Late development of TFU tools delayed the appropriate follow up of staff trained early in the project. Lengthy delays in refurbishing the training center caused delays in the initiation of training activities. These are all issues the City Health Department aims to address.

The Final Subproject Report appended to this document provides further details on the activities and achievements of this subproject.

5. Gweru Youth Reproductive Health Subproject

Under its Urban Initiative, SEATS worked with the Gweru City Health Department to expand the Gweru Family Planning Service Delivery Subproject by developing a special component to specifically address the RH needs of youth, an underserved segment of the population. The focus of this subproject was on improving the provision of services to youth, incorporating efforts to adopt better practices in support of dual contraceptive methods.

The City of Gweru formed a special youth committee - composed of representatives from central ministries, local government, and NGOs – to give special consideration to a comprehensive approach to the issues of its young people. A baseline survey, interviewing 250 youth from five high-density residential areas, was conducted to identify the major concerns facing Gweru's youth. The SEATS subproject was one part of the city's broad youth program responding to reproductive health and other identified needs. The overall goal of the SEATS subproject was **to improve the reproductive health of adolescents and youths age 10-24 in Gweru City through improved access to quality information and friendly services.**

The objectives and accomplishments of the subproject are as follows:

Objective 1: To increase knowledge on selected sexuality and reproductive health issues

- ◆ Advocacy activities and community mobilization were conducted to change the attitudes of key decision-makers to support youth RH services.
- ◆ Forty-three service providers were trained in human sexuality and communications and counseling, to better serve, understand and promote responsible behavior in youth.

Objective 2: To increase utilization of available clinical reproductive health services by youth in Gweru

- ◆ Youth corners were added in three clinics in Gweru City.
- ◆ The Gweru City Health Department staff is now conducting training in youth-friendly health services, rather than hiring consultants from ZNFPC.
- ◆ Youth coordinators attended SEATS' Quality Workshop in Harare, which focused on continuous quality improvement and program monitoring and evaluation. As a result of the workshop, Gweru City Council formed a quality team that visits each clinic monthly.

Objective 3: To involve youth in designing and delivery of reproductive health information and services

- ◆ Forty peer educators were trained to work at the youth corners, conduct outreach activities, and keep records on their activities and services.
- ◆ Peer educators received refresher training to maintain their counseling skills.
- ◆ Peer educators began small income generating programs to support their activities.
- ◆ Peer educators and coordinators participated in exchange visits between clinics. One coordinator visited youth programs in Zambia and four peer educators and a coordinator visited youth programs in South Africa.

- ◆ Peer educators have conducted outreach activities aimed toward youth who do not attend either clinics or youth centers.
- ◆ Supportive supervision visits are made by project coordinators to peer educators both in youth corners and during outreach activities.

Objective 4: To assess effectiveness of the youth center in providing adolescent reproductive health information and services

- ◆ The Ndlovu Youth Center was renovated to add equipment and space for the nurse to counsel and examine clients, and to create a resource center for educational and other activities.
- ◆ The center is using trained peer educators to help provide information and counseling.
- ◆ Two club instructors at the center were trained with service providers in youth counseling.

Gweru youth have been responsive to the improved services at clinics and the youth center. The training of providers and peer educators has improved both the access to and quality of services for youth in Gweru City. Participation and approval from the community, generated through advocacy activities has been instrumental in implementing youth-friendly services, and in allowing youth to feel comfortable accessing the services. Additional community mobilization, however, is necessary to assure the continued support for these important services.

Several constraints were faced by this subproject, some of which may jeopardize its long-term sustainability. Coordinators had difficulty obtaining transportation to adequately supervise youth corners and peer educator fieldwork. As well, many youth do not have access to the youth center because of distance and lack of transportation. Insufficient IEC materials exist for widespread distribution and media coverage of the youth program is inadequate. Various donors are being approached with requests to provide support to youth activities, and the Provincial Medical Director has promised technical support. Peer educators are attempting to raise funds as well. However, the sustainability of the program will depend on continued support for training service providers and peer educators, and continued community mobilization and advocacy activities.

The Final Subproject Report, included as an appendix to this document, provides further details on the activities and achievements of this subproject. In addition, SEATS has prepared a document *Applying Best Practices to Youth Reproductive Health: Lessons Learned From SEATS' Experience* reflecting its broad experience project-wide with youth, including the experience in Gweru. This document includes important data and information on the attitudes and behaviors of Gweru youth in regard to reproductive health, and the effects of the activities included in this subproject. A survey report¹, also provide important information on Gweru youth.

6. Expanding FP/STI Service Provision By Private Nurses and Midwives in Zimbabwe – Midwifery Association Partnerships for Sustainability

In January 1996, a study conducted by the PROFIT Project concluded that the private sector contributed 12 percent of the FP services in Zimbabwe. Although only six practicing private midwives could be identified for the study, PROFIT included in its recommendations that private midwives were a potentially valuable resource for increasing private sector FP services and ways to further develop this resource should be explored. In June 1996, SEATS, through its MAPS Special Initiative, designed and implemented a Special Study to learn more about

¹ Moyo, I., Kate Bond, Tim Williams and Lisa Mueller. 2000. *Reproductive Health Antecedents, Attitudes and Practices Among Youth in Gweru, Zimbabwe: Findings Prior to and Following the Introduction of "Youth-Friendly" Services*.

private midwives in Zimbabwe. Twenty-two private midwives were identified, and for the first time the role and scope of their practice, clients served, and factors that either enhanced or constrained their work were documented. This data served as the basis for developing the Zimbabwe Nurses Association (ZINA)/MAPS subproject (January 1997 - July 1999), partnering MAPS with the ZINA and the Independent Clinics Organization (ICO), a special interest group for private midwives under the umbrella of ZINA.

The goal of the ZINA/MAPS subproject **was to improve access to quality FP/Reproductive health care (RHC) services in Zimbabwe, by expanding the role and number of midwife practitioners in the private sector.**

The objectives and achievements of the subproject were as follows:

Objective 1: To increase the number of private midwife practitioners providing FP/STI services

- ◆ ZINA/ICO created a handbook of guidelines on how to develop a private practice for aspiring practitioners.
- ◆ Basic FP equipment and training, and community mobilization and business management skills were provided to aspiring private practitioners.
- ◆ Fifty-four midwives opened private practices and 41 additional midwives were planning to do so by the end of 1999.
- ◆ The number of private midwife practitioners increased from 22 in 1997 to over 200 in 1999.
- ◆ ICO membership increased from six members in 1996 to 186 in 1999.
- ◆ The number of private midwifery SDPs expanded to 85, serving all 10 provinces of Zimbabwe, with over 80 percent serving rural and high-density areas.
- ◆ Over 23,000 CYP were generated by privately practicing midwives (131 percent increase over the anticipated 10,000 CYP), with over 51,800 new FP acceptors.
- ◆ Over 51,000 STI clients were served.

Objective 2: To improve the quality of FP/STI services rendered by private nurses and midwives

- ◆ Site visits were conducted to determine training and equipment needs and to develop a database of private midwife practitioners.
- ◆ Basic FP equipment was provided to 109 midwives.
- ◆ Competency based FP training was provided to 97 midwives through the ZNFPC with funding from PROFIT and PSI.
- ◆ Sixty-six midwives were trained in social marketing of FP commodities.
- ◆ ZINA headquarters in Harare was established as a sub-distributor for socially-marketed male condoms and female sheaths, providing an additional source of re-supply for private midwives and an income generating activity for the association.

- ◆ FP method mix was improved by adding the female sheath at over 66 SDPs, Norplant® kits at four model clinics and VSC capability at one model clinic.
- ◆ The model clinics consortium developed FP referral guides (FPRG). Monthly orientation to the FPRG is taking place at ICO meetings.
- ◆ A consortium of 28 model clinics was developed as “Best Practice” sites to provide role models for optimum FP/RHC service provision and to serve as practice sites for aspiring private midwives.
- ◆ Each clinic developed a CQI team and began identifying problems that needed to be addressed to improve service quality.
- ◆ Sixty midwives were oriented to the CQI process (June 1997).
- ◆ FP/RHC continuing education updates are offered at each ICO meeting, attended by an average of 30-40 midwives.
- ◆ Eighty percent of private midwives meet national standards for FP service provision.
- ◆ Quality indicators were monitored and evaluated, demonstrating improvement in FP knowledge and skills, effective utilization of FP referral mechanisms, and linkage with a national FP campaign to promote quality FP services in the private sector (ProFam).
- ◆ Exit interviews and client surveys at model clinics have shown increased client satisfaction with concerns such as waiting time, obtaining commodities and other service elements.
- ◆ One hundred percent of private midwives offer FP services. Those who have not been trained to meet national standards have hired qualified staff.
- ◆ All midwives who received ZNFPC FP training showed improved knowledge and skills based on pre- and post-training test scores.

Objective 3: To strengthen the FP/RHC service provision capability and sustainability of private midwife practitioners, by creating a more enabling environment for their practice

- ◆ ICO leaders were trained in negotiating and advocacy skills.
- ◆ ICO retained a lawyer for guidance on regulatory issues and to provide representation for members in need of legal counsel.
- ◆ MAPS dissemination workshop in June 1997 promoted dialogue between midwives and officials, regulatory bodies and other stakeholders.
- ◆ ICO carried out 101 site visits disseminating information to private midwives, reducing their sense of isolation and promoting ICO membership.
- ◆ Negotiations and lobbying for policy change and increase in reimbursement levels for private midwives were initiated.
- ◆ Linkages between ICO, PSI, ZNFPC and donors were developed to provide a collaborative approach to addressing restrictive barriers to procurement and dispensing FP commodities by private midwives.

- ◆ ICO developed a Position Paper documenting the status of private midwives and making recommendations for addressing the mutual concerns of ICO, MOH and others in ensuring the quality of services.
- ◆ Regional and international networks were developed to link ICO with other nursing and midwifery associations.

The full potential of private midwives has yet to be realized in Zimbabwe. Significant barriers to practice still exist, such as restrictions on procuring and dispensing FP commodities and other RHC drugs (e.g., antibiotics), and offering immunizations. Despite practice obstacles, at the close of the ZINA/MAPS subproject, private midwives were better positioned to constructively address these issues as a result of the capacity building of their professional organization, the ICO, including the development of referral guidelines and training and experience in community mobilization and business management. Support for the contribution of this cadre of practitioners has been garnered from key representatives in the MOH, influential members of parliament, Health Professions Council, ZNFPC, and other relevant stakeholders. Most important, clients find that the services of private midwives are personalized, convenient, and affordable (Special Study 1996).

The Final Subproject Report, included as an appendix to this document, provides further details on the activities and achievements of this subproject.

B. SEATS Special Initiative - Integration

For the most part, SEATS Special Initiatives were fully integrated into the Zimbabwe country program/subprojects. As described above, subprojects were developed with a focus on and support from the resources devoted to MAPS, Urban and Youth Special Initiatives. The single exception was implementation of the Integration Initiative, which was designed to assist NGOs integrate FP/RH into their existing programs.

SEATS developed a handbook, conducted a series of workshops, and targeted TA to relay its Integration methodology and model to NGO's.

The Kunzwana Women's Association (KWA) is a Zimbabwean NGO with its headquarters in Harare. It was established in 1993 to provide social and development education and support to women residing on commercial farms, in mining communities and in resettlement areas. KWA's long-term goal is to bring women living in these marginalized communities into the mainstream of development in Zimbabwe.

In 1996, two representatives from KWA attended SEATS' first integration workshop held in Harare. Knowing that the women they worked with on farms and in other areas frequently spoke of their difficulties raising large families and their desire for family planning, KWA attended the workshop to learn more about integrating family planning activities into their existing programs. Following the workshop, KWA submitted a project proposal to SEATS. KWA became a Performance Study site and SEATS funded their proposal to launch a service delivery program through start-up funds and limited TA to the Association, and helped implement a monitoring program to guide activities. KWA's participation in SEATS' RHII Performance Study aimed to examine the effectiveness and potential pitfalls in the SEATS-designed integration model.

The KWA Family Planning Project operates in the Mashonaland East Province, about an hour outside of Harare. The project trained 18 CBDs to serve a population of 30,000. The 18 CBDs are also farm workers or relatives of farm workers. They receive a small allowance from KWA. The aim of the project is to increase the CPR in the project area from 48 to 63 percent. To maintain high-quality service and assist CBDs with job-related problems, KWA trained its four existing program officers as CBD supervisors.

KWA conducted a baseline Performance Improvement Review in April 1999. By participating in the review, KWA staff and partners came to realize what they needed to do to get the program off and running. KWA developed an action plan that they implemented over the ensuing six months. The areas addressed by the assessment included: management and organization; supply system; sustainability; quality of service; and community commitment. SEATS and KWA conducted a follow-up review in September 1999, which showed improvement in all areas, but also showed a need to continue to work on these areas. KWA developed the next six-month workplan, which it is currently implementing.

C. Regional Activities

Throughout the life of the project, SEATS has organized numerous regional activities to serve the needs of leaders and service providers from multiple countries. SEATS technical staff from central, regional and country offices have conducted these events. The placement of SEATS ARO in Harare has made this a frequent venue for regional activities, thus permitting easy access to Zimbabwe participants. With SEATS support, Zimbabwe public and private sector personnel have participated in the following:

- ◆ MAPS Dissemination Conference, Harare - Participants attended the conference which highlighted successes and reviewed lessons learned during five years of the MAPS Initiative. Participants included USAID, World Health Organization/Geneva and other donors, as well as government officials, CA representatives and midwives from Zimbabwe, Zambia, Uganda, Eritrea, Cambodia, Tanzania and the U.S. (June 1999)
- ◆ MAPS Regional Workshop, Harare - Zimbabwe midwives participated in this workshop that focused on the role of the midwives' professional associations in facilitating the members' provision of FP/RHC services. (June 1999)
- ◆ Quality and Sustainability Workshop, Harare - Participants attended a one-week workshop that reviewed key concepts and elements of quality and sustainability. Participants discovered tools to identify critical issues impacting quality and sustainability, and monitor improvements. Participants then developed plans to form quality and sustainability action plans for their organizations. (September 1997)
- ◆ Sustainability Workshop, Ivory Coast - SEATS sponsored the participants of NGO partners in a sustainability workshop conducted by the Institute for Development Research and OIC International. More than 200 delegates from Africa participated. (March 1998)
- ◆ Quality/Monitoring and Evaluation Workshop, Harare - The CQI/M&E workshop's goal was to improve linkages between CQI and M&E, and to strengthen the evaluation of quality of care in SEATS II subprojects. In addition to providing a refresher or new exposure to CQI techniques, it also emphasized the need for each quality action plan to have an M&E component with measurable objectives, appropriate indicators linked to each objective and appropriate data sources for the measurement of each indicator. (September 1998)
- ◆ Technical Exchanges (MAPS) – Two Ugandan midwives visited Gweru and Harare to see youth-friendly services and private practices, respectively.
- ◆ Regional Urban Study Dissemination, Harare - The conference aimed to develop a "new vision for urban family planning programs in sub-Saharan Africa." Ideas and proposals from this meeting led to the development of the SEATS II Urban Initiative. (1995)
- ◆ Integration Workshop, Harare – Participants attended a workshop and field tested SEATS' integration handbook: *Integrating Reproductive Health into NGO Programs Volume I, Family Planning*. (June 1996)

- ◆ Child Survival PVOs Integration Workshop, Mangochi, Malawi – Participants from USAID/W-supported Child Survival PVO programs attended the second Africa Integration Workshop using the Family Planning volume of the Integration Handbook. (September/October 1997)
- ◆ Study Tours – 10 Zimbabwe private midwives participated in the Uganda study tour. (October 1998)
- ◆ Leveraging and Proposal Writing Workshop, Harare - SEATS designed and conducted a workshop on leveraging resources for reproductive health. The 10-day workshop had two objectives: to facilitate the development of leveraging strategies by participating organizations and to contribute to the development of the SEATS leveraging guide. Representatives from seven SEATS partner organizations in southern and eastern Africa participated. Each produced an action plan for leveraging resources to support their identified needs. (March 1999)
- ◆ Technical Assistance – Backstoppers and technical staff from ARO and SEATS headquarters provided ongoing, targeted TA to the Zimbabwe program and subprojects.

Following participation in regional activities, quality and sustainability plans were developed for each SEATS subproject or activity in Zimbabwe. Quality teams were formed at SEATS-supported health and youth centers, and some staff began to develop funding proposals for needs identified in their programs.

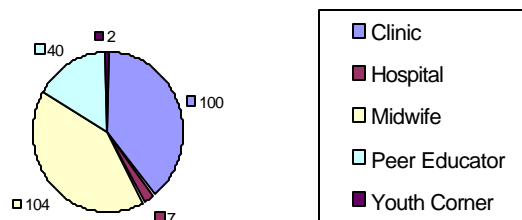
VI. ACCOMPLISHMENTS

The previous section outlined what SEATS has done in collaboration with many partners in Zimbabwe; and the appended Final Subproject Reports offer further details and data to support specific achievements. It is important, however, to consider what overall contributions SEATS II has made to Zimbabwe's national FP and RH programs, and what value SEATS has added toward the achievement of USAID's Strategic Objectives and sector goals.

A. Improved Access to RH Services

SEATS activities were designed 1) to focus on service delivery in three urban areas and on the private sector nationwide and 2) to increase opportunities for service expansion in underserved rural areas. Through renovations to youth and training centers and clinics, with materials and equipment supplied by SEATS; and through extensive training and training capacity building, both the number and service capacity of service delivery points was expanded, thereby increasing access to needed services for the population as a whole. In total, 253 sites were either created (66) or improved (187), ranging from improvements to hospitals to training peer educators (Figure 1).

Figure 1: Zimbabwe New/Improved SDP's by Type



An important aspect of improving access rests in the changed attitudes of providers and communities toward RH services for youth. In Bulawayo, training of City Health Department nurses in youth-friendly services and counseling helped reduce barriers to services for youth. In Gweru, a more favorable environment for the provision of services to adolescents included: training providers in youth-friendly services; training peer educators in outreach and information provision to other youth; and institutionalizing youth involvement in the design and delivery of information and services. A combination of youth-friendly services and peer education outreach and referrals led to an increase in youth being seen at the city clinic's for STI counseling and testing (from only five young clients in one quarter to 203 in the next).

These efforts collectively ensure better access for youth to more appropriate and acceptable RH services and are one way SEATS increases the number of new users accessing RH services. Figure 2 shows the trend in numbers of new users served during the life of SEATS activities in Zimbabwe. The number of new users positively affected the increase in CYP in the Zimbabwe subprojects.

- ◆ In Gweru Urban Subproject, approximately 46,485 CYP were generated.
- ◆ By the end of April 1999, approximately 18,599 CYP had been generated in the Bulawayo VSC Subproject from UBH and Mpilo alone, nearing the target of 22,000 CYP set in the M&E plan. (The target included service data from an additional site (ZNFPD) which was not collected).

- ◆ Bulawayo FP Subproject aimed to generate 40,000 CYP, and by the end of the project, 70,149 CYP had been recorded.
- ◆ Overall, comparing beginning and ending quarters, aggregate CYP from all subprojects increased by 31percent. A total of 221,939 CYP were provided and 110,143 new users were served.

Figure 2: Zimbabwe New Users During SEATS Activities

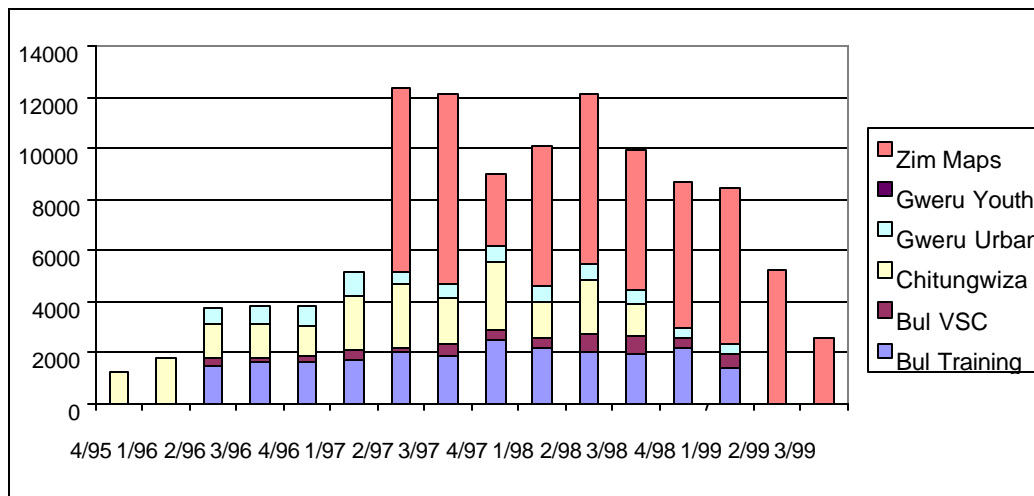
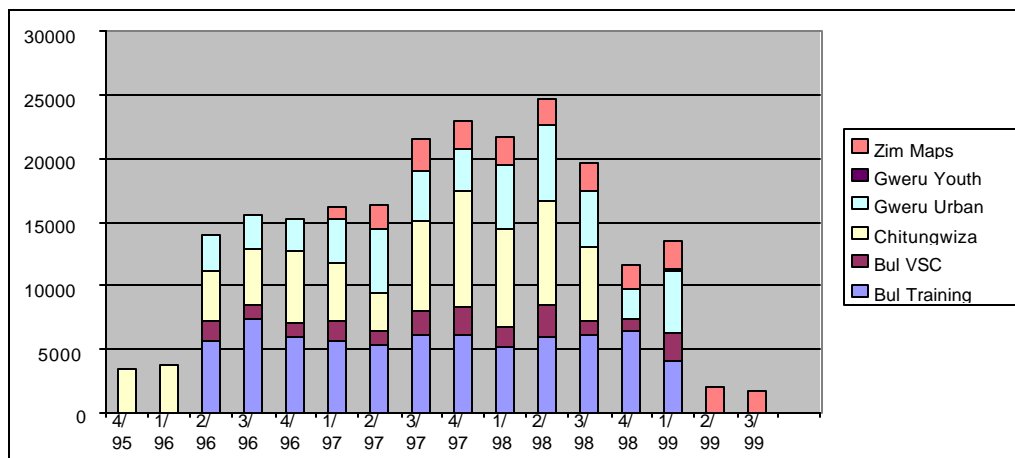


Figure 3: Zimbabwe CYP's by Subproject



SEATS has utilized innovative approaches to increase the number of FP/RH service users and to expand the method mix in Zimbabwe, thereby increasing access to needed services. For example, in ZINA/MAPS, the number of private midwife practitioners in Zimbabwe grew from six in 1995 to more than 200 in 1999.

B. Improved Quality

SEATS' goal is to expand the access to high-quality family planning and reproductive services in underserved areas. In its focus on quality, SEATS worked with the Zimbabwe subprojects to expand the proportion of CPR attributable to long-term and permanent methods reducing

the demand on resupply methods, introduce and strengthen services to youth, and invest in the training and human resource development of the implementing agencies.

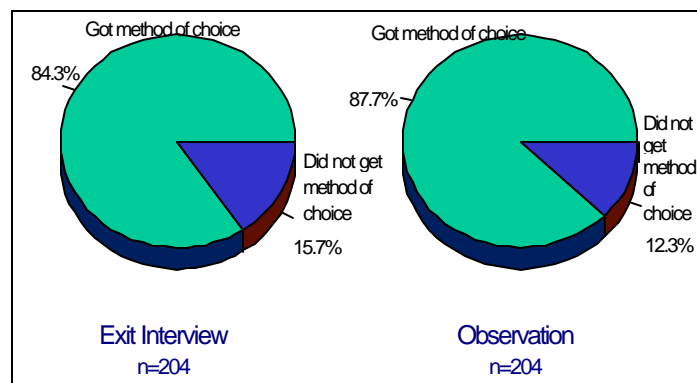
In addition to the quality components included in each subproject, SEATS/Zimbabwe subprojects and activities also participated in USAID's MAQ Initiative. This was a unique opportunity for SEATS to monitor the quality of care of each subproject.

1. MAQ-MEASURE Survey

SEATS collaborated with the MEASURE-*Evaluation* Project and with USAID's MAQ Initiative to field-test an innovative methodology for monitoring quality of care. To be as practical and low-cost as possible, the tools used three instruments (a facility audit, an observation guide, and a client exit interview) to measure 24 key quality of care indicators. In early 1999, the collective of SEATS' Zimbabwe subprojects served as one of four initial sites to field-test these instruments, with SEATS' ARO managing and analyzing the survey. The study covered all 39 facilities – both public and private – supported by SEATS. Exit interviews were conducted with 742 family planning clients visiting these facilities and 753 were observed in counseling and clinical sessions. The findings of the survey shed valuable light on the quality of care provided in those projects and demonstrated the importance of the tools in planning and evaluating work to improve the quality of care. Key results, according to the Bruce-Jain framework, were as follows:

Choice of method: The facility audit showed that 90 percent or more of the clinics visited had most methods – pills, condoms and injectables – available. Only 67 percent, however, had IUDs in stock and only three percent had spermicides, effectively limiting clients' choice of methods in many facilities. Across the board, contraceptive supplies were properly stored on shelves, protected from sun and rain. Exit interviews with clients indicated that providers had discussed their clients' preferred method in 88 percent of cases and 84 percent of clients actually received their method of choice. (Figure 4) Direct observation suggested that a slightly higher percentage (88 percent) obtained their method of choice.

Figure 4: Client Method of Choice



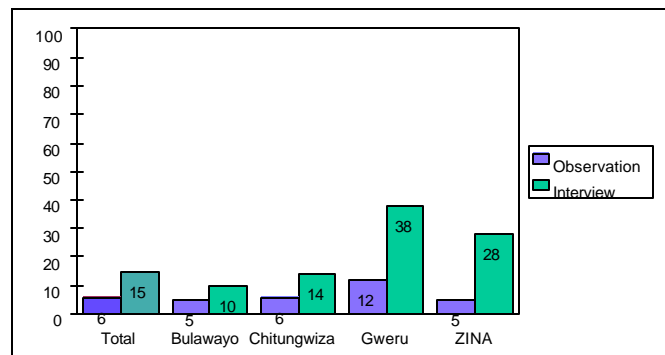
Information given to clients: Overall, the study showed that clients had relatively good general knowledge of how to use their chosen method. Exit interviews showed that 100 percent of pill and IUD users could describe accurately how to use their method, while 96 percent of clients using injectables and 86 percent of condom users could do so. The relatively low score for condom users, however, is a concern in Zimbabwe (the question asked was "how many times can you use a condom?"). Observations of providers showed somewhat lower figures, with information about method use given to 82 percent of new clients. Information about side effects was given to about 67 percent of new clients.

Although providers gave relatively good information to their clients, their counseling skills could still be strengthened. Based on a composite "score" of eight provider actions during

counseling, providers achieved an average of 6.4 out of eight. Moreover, according to the observations, only nine percent of the items discussed during counseling were raised by clients, indicating that providers tended to give information to clients rather than engage in a dialogue. Nevertheless, 95 percent of clients said in exit interviews that they felt comfortable asking questions and 76 percent said they had been given the right amount of information.

The MAQ-MEASURE survey revealed that it was the exception rather than the rule for HIV/STIs to be discussed – a dangerous omission in a country as seriously afflicted with AIDS as Zimbabwe. In only 10 percent of cases were providers seen to discuss whether the client's chosen method provided protection against HIV; and only 15 percent of clients reported that HIV/AIDS/STIs had been discussed during their visit. (Figure 5)

Figure 5: MAQ-MEASURE Survey
HIV/AIDS/STD Discussion with Clients by Provider



Technical competence of providers: Ninety-five percent of clinics had written guidelines for FP services available, enabling providers to seek guidance on technical issues when necessary.

Providers were observed during provision of injectables to see if they were following key infection prevention procedures. In all observed cases, they used sterile syringes, but they were less likely to clean and air-dry the injection site properly - that occurred in 85 percent of cases. The practice of hand washing before giving the injection was only performed adequately - in six percent of cases.

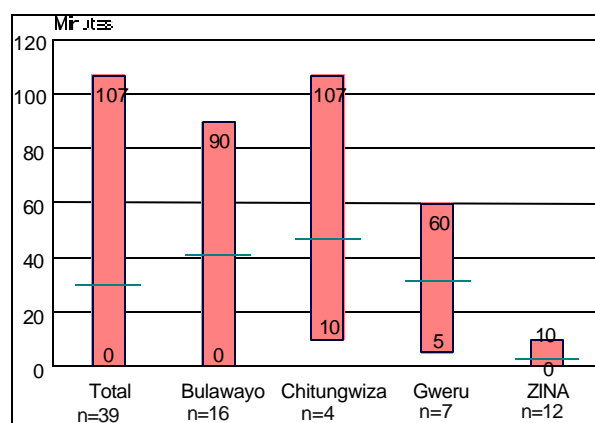
Providers were also observed to see if they followed selected clinical procedures for pelvic exams. The results showed that they prepared the instruments beforehand in 74 percent of cases; inspected the external genitalia and/or the cervix/vaginal mucosa in 90 percent of cases; asked the client to relax in 77 percent of cases; explained insertion of the speculum in 85 percent of cases; and performed the bimanual examination gently in 80 percent of cases.

Interpersonal relations: Clients reported that the provider had tried to make the interaction respectful in 98 percent of cases. This was verified by observed sessions, where 99 percent of providers were judged to have treated the client with respect.

Continuity of care: Clients were given instructions on when to return for the next visit in 83 percent of cases observed, although only 72 percent of clients recalled being told this when asked.

Appropriateness and acceptability of services: According to clients, clinics offered adequate privacy for the clinical exam in 98 percent of cases. The average wait for service was found to be about 30 minutes, ranging from an average of just a few minutes to about 45 minutes in different projects. Waits could run to as much as 1¾ hours in busy city clinics. (Figure 6)

Figure 6: Client Mean Wait Times



In summary, service providers at SEATS' sites in Zimbabwe were offering relatively high quality family planning services. They offered privacy for their clients, had a range of methods available, treated clients with respect and followed infection prevention measures. However, the survey indicated areas where quality could be improved, such as discussion of HIV/AIDS/STI prevention issues, information on potential side effects, certain infection control procedures (e.g., hand-washing) and reduced waiting times.

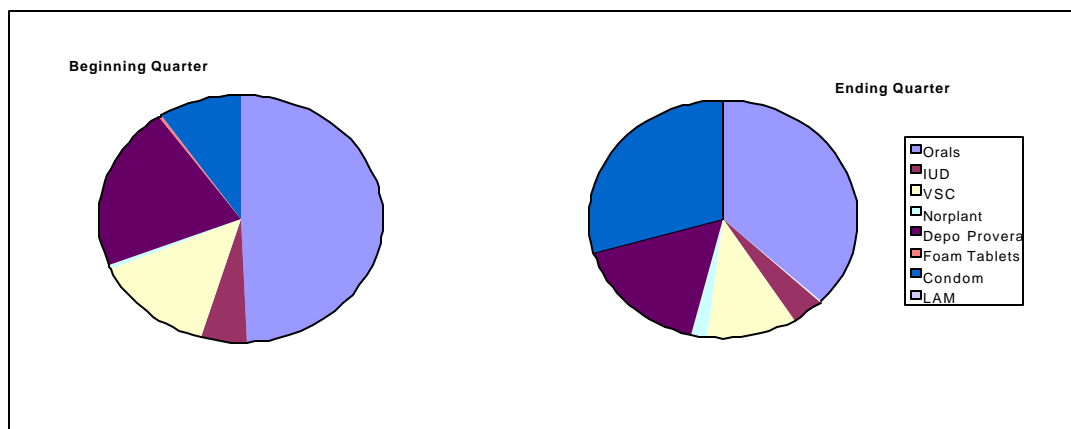
SEATS held three dissemination meetings in Zimbabwe within a few months of completing the survey, offering local stakeholders a chance to see and discuss the results, identify areas for improvement, and consider possible approaches to improving the quality of care.

The MAQ-MEASURE survey provides a "snapshot" of quality at the SEATS subproject sites, but does not demonstrate any change over time. It is likely that the relatively high quality of services offered is due, at least in part, to the strong emphasis placed on quality issues across the SEATS subprojects, and to the extensive training and planning for quality of care that was undertaken throughout the life of the project.

2. Method Mix

An important objective for the SEATS program in Zimbabwe was to expand the proportion of CPR attributable to long term and permanent methods, thereby reducing reliance on resupply methods. In both Bulawayo and Chitungwiza, VSC facilities and training were expanded and upgraded. Although pills and resupply methods continue to dominate the method mix, there has been an increase in the availability and use of long term and permanent methods. Figure 7 shows the change in method utilization over the life of the project.

Figure 7: CYP Method Mix in Zimbabwe Subprojects



3. Youth Focus

Promoting and strengthening youth-friendly health services played an important role in addressing the needs of this most underserved segment of the Zimbabwe population. To this end, subproject activities created a system for recruiting, training and supervising 40 peer educators.

Establishing youth corners in clinics and providing services at youth centers improved access to and quality of these needed services.

4. Training/Human Resource Development

One of SEATS' most important strategies in Zimbabwe was to increase or create training capacity at the municipal level in several urban areas. All of the SEATS subprojects and Special Initiatives included elements of enhanced human resource development, ranging from the construction and equipping of training centers, to regional workshops, to continuing education for service providers. A TFU system was also instituted to monitor the results of training, take corrective actions, and revise training as appropriate. The TFU tools were used as a supervisory mechanism, with the supervisor or trainer conducting the observations or interviews. Additional information or corrective measures can be provided immediately in this way. Some findings from a small sample of trainee follow-up tools are shown in Figure 8.

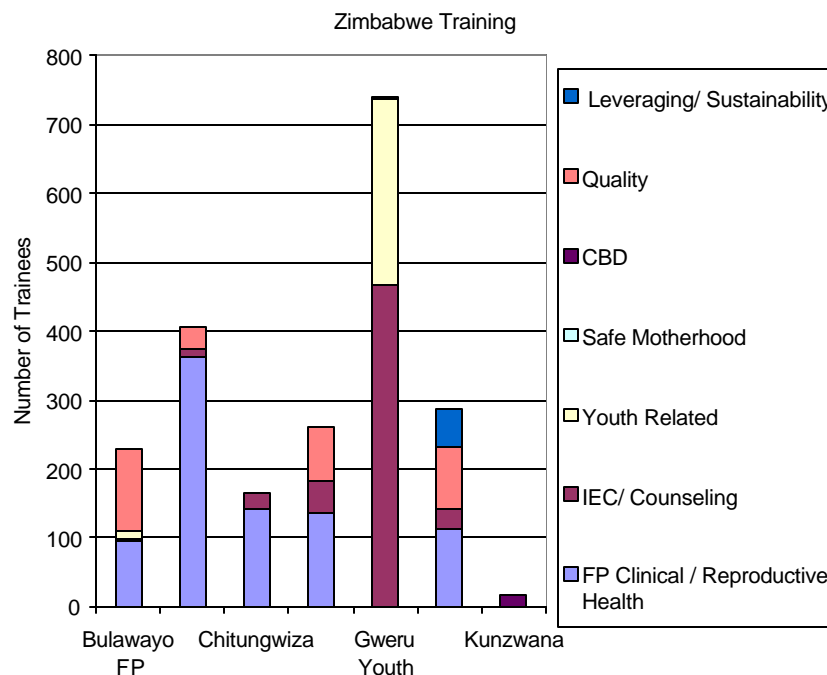
Figure 8: Trainee Follow-Up Results

(a) Skills Assessed	Total Possible Score*	Score Achieved (out of 100%)
Prepares Counseling Setting and Materials	6	5 (83%)
Establishes Client's Needs	16	15 (94%)
Explains Methods According to Clients Needs	30	22 (73%)
Helps Client to Select a Suitable Method	14	12 (86%)
Uses the appropriate Counseling Skills	12	10 (83%)
Total Score	78	64 (82%)

* Usually equal to the number of actions assessed

Rigorous and well-designed training is generally considered an effective approach to quality improvement, especially when coupled with careful follow-up monitoring and targeted technical assistance. SEATS designed and delivered a significant amount of training to Zimbabwe service providers, program managers, community members, youth, government officials and organizational leaders. The number and types of training provided by SEATS are reflected in Figure 9.

Figure 9: Zimbabwe Training



(This figure does not reflect all of the training provided through regional workshops on quality, sustainability and M&E [discussed in Section V]).

C. *Improved Sustainability*

Involvement, commitment and ownership by collaborating organizations, local governments and the community have led to sustainable activities that reflect the needs of constituents.

- ◆ In Bulawayo, the municipality has “adopted” the training center built under SEATS II by including financial commitments to support the facility and its staff in the municipal budgets. It has continued to hold trainings since SEATS support ended.
- ◆ Chitungwiza now has three-member training teams to carry out FP training for the entire municipality and to contract out to other organizations as a source of income. As a result, Chitungwiza has significantly reduced the costs incurred from when training was done by ZNFPC.
- ◆ Likewise, in Gweru, SEATS trained nine service providers (from the provincial hospital in Gweru, the police and the military units available in Gweru, PSI/Zimbabwe and the City Health Department) to conduct FP/RH training, thereby assuring the availability of a diverse cadre of FP trainers and building local capacity for training. To generate supplemental income, the city is now renting out the training school when it is not in use and is charging a fee for training non-city health employees.
- ◆ Youth Peer Educators in Gweru have initiated income-generating projects and have leveraged donor assistance to support their FP/RH information and service delivery activities, including selling cold drinks at the youth center.
- ◆ ZINA/ICO presented a position paper to the MOH and other stakeholders clarifying issues on private midwifery practice. Additionally, ZINA/ICO has developed a proposal to establish a model outpatient clinic for private midwifery RHC services, which will serve as a practicum site for continuing education sessions for students requiring clinical experience. It is expected that this clinic will be a source of revenue to fund ongoing association activities.

D. *Improved Institutional Capacities*

From government and municipal institutions to private professional associations to NGOs, SEATS has worked effectively to increase technical and management capabilities. Training capacities and support for LTPM have led to greater availability and wider range of method choices. Institutional abilities to monitor and evaluate programs and activities have improved through theoretical training and direct experience with SEATS assistance. New appreciation for and interest in strategic planning and planning for sustainability have been brought about by rigorous efforts to include them as essential elements in program design and throughout the implementation and evaluation phases of subprojects and activities. Data-driven decision making in program planning and resource allocation, as implemented under the Urban Initiative, has been enhanced through carefully crafted approaches to needs assessment, design and monitoring exercises. Ensuring broad participation of stakeholders throughout the program cycle has both increased support for needed programs and improved the potential and mechanisms for sustainability.

Through all of the activities supported under SEATS, extensive collaboration with other donors and CAs has been critical. The collaboration experienced under specific project activities has expanded both the knowledge and ability of Zimbabwe institutions to pursue ongoing support from a variety of sources – national and international alike.

VII. KEY LESSONS LEARNED

Referring to the Final Subproject Reports appended to this document, each subproject, Special Initiative and study has generated lessons, best practices, and innovations that can help guide future RH planning and programming in Zimbabwe. For this Final Country Report, however, only a few have been selected as examples that SEATS believes are most significant or noteworthy.

Access

Multiple approaches can be pursued to maximize access through underutilized resources. Comprehensive, multiple intervention approaches can meet the needs of many audiences, including youth and other special segments of the population. While access to contraception and information is not sufficient to address the root causes of risk behavior, it is an essential step.

Quality

Institutionalizing a client focus in health facilities, city health departments and private providers can help build support for services, encourage and facilitate utilization of services and help improve the quality of services offered.

Sustainability

The introduction of training fees for non-city health department providers in newly established municipal training centers (e.g., Bulawayo) can serve to generate income for the center and allow training of non-city health department service providers at a reasonable cost. In Bulawayo, charging of fees was gradually introduced as a mechanism for sharing the recurrent costs of the program. The City Council opened the training to private individuals, and by the end of the project, the demand for training was higher than the availability of training staff. These important elements increase the potential for sustaining the training center.

Youth

Involving the community (e.g., parents, youth and community leaders) in program design, implementation and evaluation is highly acceptable to those being served and helps promote youth-friendly services. When youth respond favorably to peer educators and youth corners, RH service utilization can increase as a result. The youth center in Gweru has proven very popular with youth, but to date, mostly for recreation. Getting meaningful numbers of youth to use the RH services at the center has taken longer to achieve than anticipated. The Gweru City Council, however, is still optimistic that increased numbers of youth will use the center for RH services and information in the future.

MAPS

Midwives as integral, trusted members of the community, working in both rural and urban settings, are well positioned to serve “hard-to-reach” populations such as youth, women and children at risk, men, and often isolated or underserved areas, such as family communal farms and mining communities. Private midwives are highly motivated to provide quality services, as their reputation in the community and their livelihood depend on it.

VIII. RECOMMENDATIONS

The lessons, innovations and best practices cited in the previous section suggest directions and approaches that SEATS would recommend the GOZ and USAID/Zimbabwe consider in future FP/RH programming. The Final Subproject Reports, appended to this document, and the “Applying Best Practices to Youth Reproductive Health: Lessons Learned from SEATS’ Experience” paper include many specific recommendations addressed to various partners in Zimbabwe. Some of the more notable and/or urgent recommendations are set forth below:

- ◆ GOZ and USAID should continue to support efforts and programs that identify and develop underutilized and unconventional resources to increase access to FP/RH services and information.
- ◆ Successful models of trainee follow-up should be adopted and adapted in all programs that include training components as part of their implementation plan.
- ◆ Programs should promote and implement decision making (program planning, evaluation, and modification) at the local level, using data-driven approaches and techniques. Every effort should be made to include the broadest array of stakeholders.
- ◆ Projects of short duration are less likely than longer programs to achieve positive impacts on important client outcomes. Program support, therefore, should, to the extent possible, be provided on a multi-year basis.
- ◆ Re-deployment of trained staff to areas where VSC facilities are not available or functioning reduces their motivation and results in loss of skills over time. Specific strategies are needed for ensuring continued motivation of VSC teams/staff in order to sustain and further promote and develop this method.
- ◆ The levying of fees on FP services should be allowed, including examination, counseling and consultation. With increased focus on quality of services, the costs of materials and the need for more technically competent staff add considerable financial demands on providers.
- ◆ Policy reforms are needed to remove restrictions on private midwives providing a full range of FP/RH services, as well as immunizations, and to remove restrictions on private midwives procuring and dispensing over the counter drugs and contraceptives. Private midwives need to be further empowered to address practical issues and advocate for RH policy reform in Zimbabwe.
- ◆ Program support for HIV/AIDS prevention is urgently needed, especially in terms of providers counseling skills. More work should be done to involve men in HIV prevention.

IX. APPENDICES

Volume II - Subprojects